formation of the Public Health Service (NIH) committee to which Dr. Ungerleider refers. It was actually created, however, not because of FDA problems, but as an interagency device to stimulate research in areas where controlled drugs may be useful—as in such conditions as glaucoma, chronic pain and nausea, and vomiting secondary to cancer chemotherapy.

As Dr. Ungerleider must realize, at least three separate federal agencies are involved in drug abuse issues: the Drug Enforcement Agency (DEA), the National Institute for Drug Abuse (NIDA) and the Food and Drug Administration. Each organization has a distinctive function *mandated by Congress*. We work together, as well as we know how, to reduce bureaucratic problems in a complex regulatory environment not of our own design.

Dr. Ungerleider also cites FDA's alleged refusal to allow women of child-bearing potential to participate in the testing of marijuana for cancer chemotherapy patients. It is difficult to know what he is complaining about; as he knows perfectly well, his own comments on that policy led to FDA's revision of it. One of the points in my article was that FDA is working with health professionals to solve problems. He raised one, and we solved it together. Am I missing something?

Finally, although it is true that marijuana remains in Schedule I of the Controlled Substances Act, this classification is now under medical and scientific review; it will be discussed at the next meeting of the Controlled Substances Advisory Committee. To state that this position is "absurd," and that it continues to "bode ill for the research and treatment communities" is hyperbolic. The claim that research on drugs and their investigational use in treatment has been delayed when drugs are in Schedule I is by no means unclouded. Other factors—lack of funds, lack of good scientific ideas—are also involved.

Let me reiterate the promise that FDA's hopes for communication with health professionals are genuine, and that we are prepared to confess some sins—even "bumbling"—as our part of that process. But I scarcely know how to deal with the kind of hostility displayed in Dr. Ungerleider's letter. It goes so far beyond the specific arguments he cites—even if one were to grant their truth—that I think it must relate to another agenda entirely.

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The Abortion Crisis—A Countervailing View

TO THE EDITOR: Considering the fact that Dr. DeLee's opinion on the abortion issue (Correspondence, December 1977) is not the only one extant within the profession, publication of the following countervailing views would seem to be in order—if your readers are to get the full picture and a more balanced perspective on this matter.

The burden of DeLee's argument is that the children who might be born to Medicaid recipients (at least the great majority of them) are destined to become either criminals or pregnant (probably both equally bad in his book), and will therefore cost taxpayers an untold amount of money. This is a prime example of what Allen Chase calls scientific racism; that is, the belief that poverty and its attendant problems are heritable defects that can be eliminated only by wiping out the poor. (See his new book *The Legacy of Malthus,* which is well worth reading.)

On the contrary, proper prenatal care, nutrition, education, and the like, can, in fact, make poor children as "socially desirable" as yours or mine. These programs will also cost a lot of money, but the investment will be well worth it, and this solution is far more in keeping with the announced purposes of the medical profession than genocide against the poor.

In this context, it is important to note that no one questions the existence of the social and economic problems to which DeLee alludes. But many of us still do not accept the concept of expediency; that is, that the ends justify the means. Nor do we accept utilitarianism, that the determining consideration of right conduct should be the *usefulness* of its consequences.

In another of his arguments, DeLee again puts forth the old canard to the effect that refusing to perform an abortion amounts to "forcing" a woman to bear an unwanted child. Unless pro-abortionists are expecting us to buy the incredible proposition that the million plus abortions done annually are the result of rape, we assume that the choice about bearing an "unwanted" child can be (and should be) made before the woman says "yes" to intercourse.

In this context, we are being asked, it seems, to believe that women who say "yes" to intercourse can't control themselves, don't know their own minds or don't know the implications of their

decisions; that is, that they have no real choice. But at the same time, we are being asked (by the same proabortionists) to believe the contrary proposition: that the very same women do have a real and meaningful choice when they say "yes" to abortion.

Why are the same women so competent, astute and omniscient in one situation, but so incompetent, inept and ignorant in the other? It would appear that the proabortionists can't have it both ways. Such special pleading just won't wash.

Regarding Dr. DeLee's statement "the rights and opinions of others deserve respect, too"; I would concur in it, and give it even greater emphasis by reminding Dr. DeLee, and other like-minded persons, that this also applies to prolife people (who are also full-fledged citizens and taxpayers)—and to their consciences.

After all, DeLee is not merely addressing himself to the question of whether or not someone or anyone should be *legally* (as opposed to *economically*) impeded in seeking an abortion. We are dealing here, primarily, with the question of whether or not those who vehemently disagree with the "moral" perspective expressed by DeLee shall be *forced* (by the police power of the state) to contribute with their tax dollars to the implementation of institutionalized crimes against humanity, and thus be *forced* to become accessories before and after the fact—against their loud and repeated conscientious objections.

Finally, let me just observe that it hardly redounds to the credit of organized medicine, which has continually paid loud lip service to the concept of "freedom of conscience" (especially in the area of abortion) to be now supporting the ongoing assault, by those such as DeLee, against the consciences of what is, admittedly, now a defenseless minority of physicians within medicine's own ranks.

Although such attitudes about the "freedom to conscientiously object" are now held apparently only by a minority within our profession, fortunately such views are still held by the majority of the larger society (if we can believe recent polls). Some of us find hope and comfort in the fact that this larger majority is now prepared to avail itself of established legal remedies in redressing its grievances against the secularistic elite (mainly in the media and academia), which has persisted in forcing *its* "moral" views on the larger society.

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The Science and the Art

TO THE EDITOR: I like your editorial in the February issue ("Trends in the Science and the Art"). I too am worried about the concept that every medication must be proven scientifically to be effective. Not only may this take a long period of time, but it removes from our armamentarium one of the most universal and powerful drugs we have, namely the placebo. If there is some evidence that a drug is effective for a certain condition, what is the harm if the Art of Medicine condones its use, even though we may suspect that it is only a placebo effect. A dash of spice does not improve the nutritional quality of food, and a dash of Art (call it magic, if you wish) may not cure the patient. But, it will improve his ability to tolerate illness until the body's intrinsic healing mechanisms are successful.

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